STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v **File No. 121722-001**

Humana Insurance Company

Respondent

Issued and entered
this 31ST day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 3, 2011, XXXXX, on behalf of her daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health care benefits under a policy underwritten by Humana Insurance Company (Humana). The Commissioner notified Humana of the external review and requested the information used in making its adverse determination. After a preliminary review of the material received, the Commissioner accepted the Petitioner's request for external review on June 10, 2011.

The issue here can be decided by applying the terms of the *Certificate of Insurance* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On January 11, 2011, Petitioner was found unconscious on the floor of her home. She was transported by ambulance to the emergency room of a local hospital for treatment. The ambulance service charged $824.10. Humana paid the ambulance service $481.96. The ambulance service billed the Petitioner for the remaining $342.14.

The Petitioner's mother appealed the benefit amount seeking 100% coverage of the ambulance charges. Humana denied payment of further benefits and issued its final adverse determination on April 25, 2011.

III. ISSUE

Did Humana correctly deny 100% coverage for the Petitioner's ambulance services?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner's mother wrote:

> [The Petitioner] was unconscious when I found her on the kitchen floor on 1-11-11. There was not time for me to find an "in-network" ambulance provider. It is a situation between insurance company and [ambulance] facility used and shouldn't be at the cost of the insured.

In a letter of appeal to Humana dated April 11, 2011, the Petitioner's mother also indicated there was not another ambulance service in-network in their area and it would have taken 45 to 60 minutes for the closest in-network ambulance provider to arrive to their home, which was not feasible given the emergency situation.

Respondent's Argument

In its final adverse determination dated April 25, 2011, Humana explained its denial of additional benefits stating:

> . . . The services provided by XXXXX Ambulance on January 11, 2011 were already paid at your network benefits up to the maximum allowable fee (MAF). The MAF of $602.45 was paid at 80 percent. We applied $120.49 toward your network coinsurance. Your policy's ambulance benefit is the same whether the ambulance service is a contracted provider or not. However non-network ambulance charges exceeding the MAF are not covered by your policy. There is no state mandate in Michigan that states ambulance claims should be paid at the billed charges.

Commissioner's Review

The schedule of benefits in Petitioner's certificate indicates that the benefit payable for both network and non-network providers is 80% after the deductible is assessed. The certificate's "Covered Expenses" provision, on page 34, states:

> *We* will pay benefits for *covered expenses* incurred by *you* for professional *ambulance* service to, from or between medical facilities for *emergency care*.
>
> *Ambulance* service for *emergency care* provided by a *non-network* provider will be covered at the *network provider* benefit percentage, subject to the *maximum allowable fee. Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee. You* may be required to pay any amount not paid by *us*.

The term "maximum allowable fee" is defined in the certificate's glossary:

> ***Maximum allowable fee*** for a *covered expense* is the lesser of:
>
> - The fee charged by the provider for the services;
> - The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
> - The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
> - The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
> - The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
> - The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.
>
> **Note:** The bill *you* receive for services from *non-network providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *maximum allowable fee* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

In this case, the provider charged $824.10. Humana determined the maximum allowable fee was $602.45. Humana assessed 20% ($120.49) to the Petitioner's coinsurance, leaving a balance of $481.96 which Humana paid to the ambulance service. The remaining $342.14 was billed to the Petitioner by the ambulance service.

The Commissioner finds that Humana correctly calculated the Petitioner ambulance benefit.

V. ORDER

The Commissioner upholds Humana Insurance Company's adverse determination of April 25, 2011. Humana is not required to provide any additional coverage for Petitioner's January 11, 2011, ambulance service.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.